FEA, Confidential Management and Non-Management, Elected Officials, FPFA, FFMA, Executive Management, FGMA
excludes FPOA, FPMA

2012 City of Fairfield Health and Dental Plans
Effective for the Period of January 1 through December 31, 2012

Health Plan	Copayments	Monthly Premium		City Monthly Contribution	Employee Monthly Contribution
Kaiser HMO $10	$10 Office Visit $5 / $15 Rx *includes vision*	EE Only EE + 1 Dep EE + Family	$606.55 $1,213.09 $1,716.52	$462.68 $925.35 $1,309.38	$143.87 $287.74 $407.14
Kaiser HMO $15	$15 Office Visit $5 / $15 Rx *includes vision*	EE Only EE + 1 Dep EE + Family	$507.53 $1,015.05 $1,436.30	$462.68 $925.35 $1,309.38	$44.85 $89.70 $126.92
Health Net HMO $10	$10 Office Visit $10 / $15 / $35 Rx *includes vision*	EE Only EE + 1 Dep EE + Family	$788.93 $1,577.86 $2,232.67	$462.68 $925.35 $1,309.38	$326.25 $652.51 $923.29
Health Net HMO $15	$15 Office Visit $10 / $20 / $35 Rx *includes vision*	EE Only EE + 1 Dep EE + Family	$696.37 $1,392.74 $1,970.73	$462.68 $925.35 $1,309.38	$233.69 $467.39 $661.35
Health Net Point of Service	$10 / $20 / 30% Office Visit $5 / $10 / $35 Rx *includes vision*	EE Only EE + 1 Dep EE + Family	$1,248.28 $2,496.56 $3,532.63	$462.68 $925.35 $1,309.38	$785.60 $1,571.21 $2,223.25
Dental Plan					
Delta Dental Premier	Children only Orthodontia	EE Only EE + 1 Dep EE + Family	$54.54 $87.16 $129.24	$20.68 $37.60 $55.39	$33.86 $49.56 $73.85
DeltaCare USA	Adult and Children Orthodontia	EE Only EE + 1 Dep EE + Family	$21.54 $39.17 $57.70	$20.68 $37.60 $55.39	$0.86 $1.57 $2.31

The above rates are for medical and dental coverage only.
The City pays 100% of the vision benefit premium for each plan.

EE Only = Employee Only coverage

EE + 1 Dep = Employee plus one dependent coverage (the one dependent can be *any* eligible dependent)

EE + Family = Employee plus two or more eligible dependents

City contributions for medical and dental premiums combined to cover the total premium cost.

Example: Employee with one dependent selecting Kaiser $15 and Delta Dental Premier.

Plan	Premium	City Contribution	Employee Contribution
Kaiser HMO $15	$1,015.05	$925.35	$89.70
Delta Dental Premier	$87.16	$37.60	$49.56
	$1,102.21	$962.96	$139.25

$1,102.21 minus $962.96 equals $139.25 per month
(or $69.63 per pay period)

Contact Information

Kaiser	http://my.kp.org/ca/cityoffairfield	(800) 464-4000
Health Net	www.healthnet.com	(800) 522-0088
Delta Dental Premier	www.deltadentalins.com	(800) 765-6003
DeltaCare USA	www.deltadentalins.com	(800) 765-6003

City of Fairfield
1000 Webster Street ● Fairfield, California
94533
www.fairfield.ca.gov

	Health Net HMO $10	Health Net HMO $15	Health Net Point of Service			Kaiser HMO $10	Kaiser HMO $15
			Select 1 - HMO	Select 2 - PPO	Select 3 - Out of Network		
Emergency Room for Emergency Care	$100 copay	$35 copay	$35 copay	$35 copay	$35 copay	$50 copay	$50 copay
Urgent Care Center	$10 copay	$35 copay	$35 copay	$35 copay	$35 copay	$10 copay	$15 copay
Hospital, Inpatient Semi-Private	No Charge	$250 per Admit (2 max)	No Charge	10%	30%	No Charge	No Charge
Hospital, Outpatient	No Charge	No Charge	No Charge	10%	30%	No Charge	No Charge
Office Visit	$10 copay	$15 copay	$10 copay	$20 copay	30%	$10 copay	$15 copay
Well-Baby, Well-Child, Adult Routine and Preventive Services	No Charge	No Charge	No Charge	No Charge	Not Covered	No Charge	No Charge
Home Health Visit	$10 copay 100 visits	$15 copay	$10 copay	$20 copay 100 visit maximum combined PPO & OON	30%	No Charge 100 visits	No Charge 100 visits
Hospital Visit, Inpatient	No Charge	No Charge	No Charge	10%	30%	No Charge	No Charge
Surgeon, Assistant Surgeon, Anesthesia	No Charge	No Charge	No Charge	10%	30%	No Charge *except* Outpatient is $10 per procedure	No Charge *except* Outpatient is $15 per procedure
X Ray and Lab	No Charge *except* CT SPECT, MRI, MUGA, PET $100 per procedure	No Charge	No Charge	10%	30%	No Charge	No Charge
Maternity Hospital, Inpatient	No Charge	No Charge	No Charge	10%	30%	No Charge	No Charge
Maternity Office Visit	$10 copay per visit	$15 copay per visit	$10 copay per visit	10%	30%	No Charge	No Charge
Mental Health, Inpatient	No Charge	$250 per Admit (2 max)	No Charge	10%	30%	No Charge	No Charge
Mental Health, Outpatient	$10 copay	$15 copay	$10 copay	$20 copay	30%	$10 copay	$15 copay
Substance Abuse, Detoxification	No Charge	$250 per Admit (2 max)	No Charge	10%	30%	No Charge	No Charge
Substance Abuse, Inpatient	No Charge	$250 per Admit (2 max)	No Charge	10%	30%	No Charge	No Charge
Substance Abuse, Outpatient	$10 copay	$15 copay	$10 copay	$20 copay	30%	$10 copay	$15 copay
Retail Pharmacy	30-Day Supply	30-Day Supply	30-Day Supply	30-Day Supply	30-Day Supply	100-Day Supply	100-Day Supply
Generic / Brand / Non-Formulary	$10 / $15 / $35	$10 / $20 / $35	$5 / $10 / $35	$5 / $10 / $35	$5 / $10 / $35	$5 / $15 / N/A	$5 / $15 / N/A
Mail Order Pharmacy	90-Day Supply	90-Day Supply	90-Day Supply	90-Day Supply	90-Day Supply	100-Day Supply	100-Day Supply
Generic / Brand / Non-Formulary	$20 / $30 / $70	$20 / $40 / $70	$10 / $20 / $70	$10 / $20 / $70	$10 / $20 / $70	$5 / $15 / N/A	$5 / $15 / N/A
Allergy Testing	No Charge	No Charge	No Charge	$20 copay	30%	$10 copay	$15 copay
Physical Therapy	$10 copay	$15 copay	No Charge	$20 copay 60 visit maximum combined PPO & OON	30%	$10 copay	$15 copay
Durable Medical Equipment	No Charge, $5,000 max	No Charge	No Charge	50% to $5,000 max	Not covered	No Charge	No Charge
Vision Exam	$10 copay	$15 copay	$10 copay	Not covered	Not covered	No Charge	No Charge
Optical Materials	Scheduled Reimbursement	Scheduled Reimbursement	← Scheduled Reimbursement →			$175 every 24 months	$175 every 24 months
Chiropractic	Not Covered	Not Covered	$10 copay	30%, 15 visit maximum combined PPO & OON		Not Covered	Not Covered
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered		Not Covered	Not Covered

Note: This is only a summary of benefits and is subject to conditions, restrictions, and limitations. In the event of a discrepancy between this summary and the plan document, the plan document will prevail.
Please read plan document for further details. Benefits and rates are effective January 1, 2012 through December 31, 2012.

	Delta Dental Premier [1]		Dental Dental Premier Late Entrant Benefits [1,2]		DeltaCare USA
	Premier Network	Out of Network	Premier Network	Out of Network	
Annual Deductible					
Individual / Family	None		None		None
Annual Plan Maximum	$1,200 combined		$1,200 combined		No Maximum
Lifetime Orthodontia Plan Maximum					
Dependent Children	$1,500 combined		$1,500 combined		No Maximum
Employee and Spouse	Not Covered		Not Covered		No Maximum
Waiting Period	None		Limited to Diagnostic & Preventive and Basic services for the first 6 months of coverage		None
Diagnostic & Preventive Services, Basic Services including Endodontics, Periodontics	70% to 100%		70% to 100%		Scheduled copays
Major Services including Crowns, other Cast Restorations	80%	80%	Not Covered		Scheduled copays
Prosthodontics	50%	50%	Not Covered		Scheduled copays
Orthodontia					
Dependent Children	50%	50%	Not Covered		$1,600 copay to age 19
Employee and Spouse	Not Covered		Not Covered		$1,800 copay age 19 and over

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[1] Under the Premier Plan, Delta Dental pays 70% of the allowed fees for covered diagnostic, preventive, and some basic benefits during the first year you are eligible. This percentage will increase 10% each year (to a maximum of 100%) for each enrollee, provided that person visits the dentist at least once during the year. If an enrollee does not use the plan during a calendar year, the percentage remains at the level reached the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%. If you change from the Premier plan to the DeltaCare USA plan, your incentive level (70% - 100%) will drop to 70% if you return to the Premier plan. You must select from a panel of dentists if you enroll in the DeltaCare USA plan. With the Premier plan, employees can use the dentist of their choice. For specific provider information, go to www.deltadentalins.com.

[2] If employee elects not to enroll in either dental plan within 31 days of the hire date, but subsequently enrolls in the Delta Dental Premier Plan during an open enrollment period, the employee (and any dependents) will be considered a Late Entrant and limited to Diagnostic & Preventive and Basic Services for the first 6 months of coverage.

NOTICE: If you have newborn or young children whom you have not yet added to the dental plan, you may want to do so now during open enrollment. Dental eligibility is from birth. While most very young children have little need for routine dental care, dental accidents can occur. Some dental accidents can be covered under some medical plans; most, however, are covered under the dental plan. If you do not enroll your dependent children during this open enrollment, they will have no coverage through the City. New dependents can be enrolled within 30 days of birth, adoption, or guardianship only; otherwise, you will not be allowed to enroll them until the next open enrollment.